| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155620 | A. BUILDING 01<br>B. WING | 08/24/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ZIONSVILLE MEADOWS | 675 S FORD RD<br>ZIONSVILLE, IN 46077 |

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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 08/24/12<br><br>Facility Number: 000538<br>Provider Number: 155620<br>AIM Number: 100267290<br><br>Surveyor: Mark Caraher, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Zionsville Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility is a split level facility with each of the two floors exiting at ground level and was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the | K0000 | The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.<br><br>This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a **desk review** on or after September 23, 2012. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 156 at the time of this visit.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/31/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K0027 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br>Based on observation and interview, the facility failed to ensure 2 of 10 sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and are equipped with an astragal to have a coordinator to ensure the door which must close first, always closes first. This deficient practice could affect 28 residents staff and visitors in vicinity of the smoke barrier doors by the Cottage 2 elevator and by the Business Office.<br><br>Findings include:<br><br>Based on observations with the Assistant General Manager and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 08/24/12, the set of smoke barrier doors in the corridor near the Cottage 2 elevator swing in the | K0027 | **K027**<br><br>1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Door located in cottage two had a new coordinator installed on 8/27/2012 to ensure that fire doors shut in the proper order thus creating a smoke/fire barrier that is necessary to contain a fire. The coordinator on the door by the business office was adjusted to ensure that it works properly allowing the doors to close in the proper order; this was also completed on 8/27/2012<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. An audit of all fire doors within the facility was conducted to ensure all coordinators | 09/21/2012 |

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| | same direction and are equipped with an astragal but a door closing coordinator was not provided. The set of smoke barrier doors in the corridor by the Business Office swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was closed three times leaving a five inch gap between the doors which is not smoke resistant. Based on interview at the time of the observations, the Assistant General Manager acknowledged each smoke barrier door set did not close completely because the door closing coordinator was either missing or not functioning to ensure the door equipped with an astragal closes last and form a smoke resistant barrier.<br><br>3.1-19(b) | | functioned properly and all doors closed correctly in ensure the establishment of a smoke/fire barrier.<br><br>3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All fire doors will be checked during the required monthly fire drills and documented that they are functioning properly on the monthly fire drill form that is documented by the facility Maintenance Director.<br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Facility Administrator or designee will ensure that monthly fire drills and documentation accurately reflect that fire doors are functioning properly. Administrator or designee will sign off on the fire drill logs to document that they are being monitored | |

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| K0038 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a | K0038 | 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 egress door on A wing east that was not functioning properly was repaired on 8/27/2012 and now functions properly allowing for magnetic locks to automatically release after being pushed on for 15 seconds. Egress door in crystal dining room now has the proper signage stating that door will automatically unlock after being pushed for 15 seconds, satisfying the safety code standard.<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. An audit of all facility exit doors was conducted to ensure proper signage is in place and those doors with magnetic locks release when panic bar is held for 15 seconds.<br><br>3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All exit egress doors will be monitored monthly on our rolling | 09/21/2012 |

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| | delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads:<br>PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS<br>This deficient practice could affect 127 residents, staff or visitors wanting to exit the facility using the exit by Room 116 in the A East Hall and the Crystal Dining Room exit by the service corridor.<br><br>Findings include:<br><br>Based on observations with the Assistant General Manager and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 08/24/12:<br>a. the exit door by Room 116 in the A East Hall is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device, but the exit door did not release within 15 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observation, the Assistant General Manager acknowledged the exit door by Room 116 in the A East Hall is | | egress door check form that will be completed by facility Maintenance Director.<br><br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Facility Administrator or designee will ensure that monthly documentation accurately reflect that egress doors are functioning properly monthly for 4 months. Administrator or designee will sign off on the documentation to ensure that they are being monitored and properly documented on. | |

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| | equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device, but the exit door did not release within 15 seconds when the door was pushed with the application of force five separate times.<br>b. the exit doors in the Moving Forward Hall, A West Hall, A East Hall, B Hall and the Crystal Dining Room exit by the service corridor are each equipped with a delayed egress lock. Each exit door was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device except for the Crystal Dining Room exit by the service corridor which was not provided with the signage. The Crystal Dining Room exit door did not have the access code posted at the exit door but the exit door did release when the door was pushed with the application of force for 15 seconds. Based on interview at the time of observation, the Assistant General Manager stated the Crystal Dining Room exit door by the service corridor is a delayed egress door and acknowledged the exit door is not provided with signage stating the door could be opened in 15 seconds by pushing on the door release device.<br><br>3.1-19(b) | | | |

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| K0062 SS=C | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.<br><br>Findings include:<br><br>Based on observation with the Assistant General Manager and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 08/24/12, a | K0062 | **K062**<br><br>1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** New spare sprinkler heads have been ordered and are expected to arrive by 9/12/12.<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. An inventory of all the types of sprinkler heads found within the facility was conducted and spares for all identified sprinkler heads were purchased.<br><br>3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Maintenance Director will ensure that facility always has two spare sprinkler heads for each type of sprinkler head that the facility utilizes. If facility must use one of | 09/21/2012 |

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| | combined total of one sidewall spare sprinkler was located in spare sprinkler cabinets in the three sprinkler riser rooms in the facility. Sidewall sprinkler heads were observed in the facility during the tour. Based on interview at the time of observation, the Assistant General Manager acknowledged only one sidewall sprinkler was located in the three spare sprinkler cabinets.<br><br>3.1-19(b) | | the backup sprinkler heads, Maintenance Director will place order for new replacement sprinkler head to be stored as back-up<br><br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.**<br>Administrator or designee will ensure that replacement sprinkler heads have arrived on 9/12/12 | |

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| K0064 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10<br>Based on observation and interview, the facility failed to inspect 15 of 15 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 156 residents and any staff and visitors in the facility.<br><br>Findings include:<br><br>Based on observations with the Assistant General Manager and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 08/24/12, the annual maintenance tag attached to each portable fire extinguisher located in the | K0064 | **K064**<br><br>1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: All identified fire extinguishers were immediately checked and signed off on.<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. All fire extinguishers have been checked and documented on and will be checked monthly by facility Maintenance Director or designee<br><br>3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director will ensure that all facility fire extinguishers will be checked monthly and documented<br><br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program** | 09/21/2012 |

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| | facility indicated monthly inspections were not documented starting in May 2012. The following portable fire extinguisher locations did not have a monthly inspection documented for the period of May 2012 through July 2012: by Room 319, by Room 331, by Room 303, in the boiler room, in the elevator room by the dock and by the employee lounge. The following portable fire extinguisher locations did not have a monthly inspection documented for July 2012: by Room 120, by the Activity Center, by Room 217, outside the Crystal Dining Room, by the Cottage 3 Riser Room, by the Cottage 3 stairs, by the Cottage 2 Nurse's Station, by the Cottage 2 elevator and for the K-Class extinguisher in the kitchen. Based on interview at the time of the observations, the Assistant General Manager acknowledged monthly inspections for portable extinguishers located throughout the facility were not performed starting in May 2012.<br><br>3.1-19(b) | | **will be put into place.** Facility Administrator or designee will monitor fire extinguishers monthly for 4 months to ensure checks are being completed<br><br>5) **By what date the systemic changes will be completed:** Date of Completion; 8/27/12 | |

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| K0144 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.<br>3.4.4.1. | | | |
| | 1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for 1 of 1 emergency generators was maintained for 8 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on a review of "Emergency | K0144 | **K144**<br><br>1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director will ensure that the following actions take place 1) weekly generator inspections are completed which will include inspecting the battery, 2) Monthly Load tests are completed and documented on the facility monthly generator load test form, and 3) Monthly load test includes the time it takes to transfer power from the generator.<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Generator inspections will be completed per facilities preventative maintenance plan.<br><br>3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** | 09/21/2012 |

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| | 155620 | A. BUILDING 01<br>B. WING | 08/24/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ZIONSVILLE MEADOWS | 675 S FORD RD<br>ZIONSVILLE, IN 46077 |

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| | Generator - Weekly Exercise/Monthly Load Test Log" and "Weekly Generator Inspection Sheet" documentation with the Assistant General Manager during record review from 10:15 a.m. to 11:50 a.m. on 08/24/12, weekly emergency generator starting battery inspection records for the eight week period of 06/18/12 through 07/02/12 and 07/16/12 through 08/13/12 were not available for review. Based on interview at the time of record review, the Assistant General Manager acknowledged weekly emergency generator battery inspection records for the aforementioned weekly periods in 2012 were not available for review.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 2 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires | | Facility Maintenance Director will record the weekly and monthly generator tests in the facility generator book located in the maintenance shop.<br><br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Facility Administrator or designee will check the generator book to ensure that the above referenced changes are taking place each month. Administrator or designee will check the generator book monthly for 4 months. | |

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| | generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.<br>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.<br>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on a review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" and "Weekly Generator Inspection Sheet" documentation with the Assistant General Manager during record review from 10:15 a.m. to 11:50 a.m. on 08/24/12, monthly load test documentation for April and May 2012 was not available for review. Based on interview at the time of record review, the Assistant General Manager acknowledged | | | |

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| | monthly load test documentation for the period of April and May 2012 was not available for review.<br><br>3.1-19(b)<br><br>3. Based on record review and interview, the facility failed to ensure emergency power would be transferred to 1 of 1 emergency generators within 10 seconds of building power loss for 3 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on a review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" and "Weekly Generator Inspection Sheet" documentation with the Assistant General Manager during record review from 10:15 a.m. to 11:50 a.m. on 08/24/12, monthly load test | | | |

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| | documentation of emergency power transfer time for the period of May 2012 through July 2012 was not available for review. Based on interview at the time of record review, the Assistant General Manager acknowledged monthly load test documentation for emergency power transfer time for the period of May 2012 through July 2012 was not available for review.<br><br>3.1-19(b) | | | |

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| K0147 SS=D | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two residents in Room 213.<br><br>Findings include:<br><br>Based on observations with the Assistant General Manager and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:40 p.m. on 08/24/12, a refrigerator and a microwave oven were plugged into a power strip in resident Room 213. Based on interview at the time of observation, the Maintenance Assistant acknowledged a refrigerator and a microwave oven were plugged into a power strip in resident Room 213.<br><br>3.1-19(b) | K0147 | **K147**<br><br>1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Identified extension cords were removed immediately<br><br>2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Facility Maintenance director and his staff will evaluate all resident rooms to ensure that there are no extension cords or power strips being used to power, refrigerators, microwaves, coffee pots, or medical equipment. Facility Maintenance staff will remove any of the power strips found in use in resident rooms. An audit of all resident rooms was conducted on 8/27/2012 and findings were corrected immediately. | 09/21/2012 |

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| | | | 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Upon admission, all residents will be informed that they are not to use power strips or extension cords in their rooms. Management staff will include checking for power strips and extension cords on their weekly room rounds to ensure that all rooms are free of extension cords and power strips<br><br>4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Facility administrator or designee will check documentation on room round sheets to ensure that facility is in compliance with this regulation. | |